Rhode Island Cash Sickness Compensation Program*

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IN other countries, even in the early days of social legislation, temporary disability insurance programs preceded other types of social insurance. This has not been so in the United States but there is little doubt but what it would have been so had it not been for the extensiveness of unemployment which provided the impetus for the passage of the Social Security Act in 1935. Even at that, it is difficult to understand why this Act did not make any provision for the protection of workers who become unemployed through sickness or disability, as it did for those who become unemployed due to economic factors.

In 1942, Rhode Island undertook the passage of the first piece of legislation in the United States to provide a form of disability insurance, protecting those workers whose unemployment was caused by sickness. This legislation is known as the Rhode Island Cash Sickness Compensation Act.

As you well know, we have had in Rhode Island and in other states, disability insurance in the form of Workmen's Compensation programs which among other things protected workers against unemployment due to accident or occupational diseases. In addition, in Rhode Island and in other states, since 1936, we have had unemployment insurance programs which protected workers in part against unemployment wage losses due to economic factors. Between these two, there remained a gap which has been closed in part by the Rhode Island Cash Sickness program, providing further protection to groups of workers not included in either or both of the other programs, but who too suffer wage losses through unemployment caused by illnesses other than occupational diseases or accident.

The Cash Sickness program was set up so that there would be no exclusion because of age or because of the type of disability. Every worker employed by a firm which is subject to the Rhode Island Unemployment Compensation Act is automatically covered by the Cash Sickness Act, unless, and this is the only exception, he prefers to be exempted because of a religious affiliation which depends for healing upon prayer or other spiritual means. It might be interesting to note that up to the present time we have affidavits from some 39 persons who have claimed this type of exemption.

There were many factors other than the consciousness of the need and the logic of the situation which had a very direct influence on the adoption of this Cash Sickness program in Rhode Island. Among these are included the existence of the Unemployment Compensation program and the very substantial size of the Unemployment Compensation Trust Fund at the time; the requirement in the Rhode Island Act of an employee tax in addition to an employer tax; and the concerted efforts

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on the part of interested groups to effect a merit rating or employer tax reduction on the one hand, and the liberalization of the benefit structure or an employee tax reduction on the other hand.

From this, evolved the decision to establish this Cash Sickness program and to finance it by diverting 1 per cent of the employee tax from Unemployment Compensation to a Cash Sickness Fund which would be used for the payment of benefits under the Cash Sickness program. At no time has there ever been any employer tax used to finance the Cash Sickness program, and as a matter of fact, there has never been any real effort to have such a tax included.

It is not too difficult, therefore, to appreciate why the Cash Sickness Act provided that this program would be administered by the same agency which was administering the Unemployment Compensation program, namely, the Unemployment Compensation Board. In addition to this matter of being administered by the one agency, there is much more which these two programs have in common. There are very certain and definite advantages which result from the extent to which these programs are coördinated. At the same time, it should be recognized that they are not exactly identical and in a few respects at least they require a different approach. In our efforts to realize the advantages which come from close coördination, we have learned in Rhode Island that proper measures must be taken to insure avoiding the disadvantages from a failure to recognize the distinctions which exist in the two programs.

In order to be eligible for Cash Sickness benefits, any claimant must meet certain minimum requirements. In the first instance, of course, he must file his claim and all such claims during the entire claim process are handled by mail. On this claim form is indicated certain information relative to his unemployment, the onset of his illness, and whether or not he is receiving or has filed for Workmen's Compensation. This claim form must be certified by the claimant's attending physician who is required to supply information relative to his diagnosis and the extent to which the illness or disability prevents the claimant from performing his usual or customary work. While physicians are not held to an exact time limit on the duration of the claimant's illness, it is necessary that there be indicated in the first instance the probable number of weeks that the patient might be incapacitated. This, of course, is reviewed by a medical director to insure that there is indicated a reasonable duration of the illness.

Just as is the case with the Unemployment Compensation program, there are certain eligibility requirements in the Cash Sickness program. In the first place, the worker must have earned at least $100 in covered employment during his base period which, in Rhode Island, is the calendar year preceding the benefit year, beginning in April. These earnings of $100 will entitle him to the minimum weekly benefit rate which has been established, namely $6.75. If his earnings during the base period equal or exceed $1,800, he would then be entitled to the maximum weekly benefit amount allowed, namely, $18. Whether he is entitled to some weekly rate between $6.75 and $18 depends entirely on his earnings during the base period mentioned. The number of weeks he will be allowed to draw benefits cannot exceed 20 weeks, and again depends on the amount of credits he has compiled in his base period, divided by his weekly benefit rate.

With employment conditions as they are today, and the increase which has taken place in the average weekly wage since the establishment of these benefit rates, it is not difficult to appreciate that the great majority of claimants are entitled to the maximum weekly benefit.

The average duration of benefit has been approximately 9 weeks.

At the end of the probable duration of benefits which was originally certified, the claimant is disqualified unless there is additional information which indicates that he is still, because of illness, unable to perform his regular or customary work. This information is obtained either from the attending physician or from a physical examination performed by a physician designated by the agency, or as the result of a field visiting program, or perhaps in some selected cases from all three sources. If, on the basis of this information, it is determined that the claim shall be no longer allowed, and the claimant feels aggrieved thereby, he is given every opportunity to pursue an appeal, first to a referee, then to the Unemployment Compensation Board, and from there, in some cases, to a Board of Review. In the last analysis, a further appeal can be prosecuted from there to the courts.

You will observe from the time of the original certification, during the entire process of appeal, and up to the final determination, the certification and the assistance and advice of physicians are factors without which the system could not function.

We might look for a moment into the actual operations of the Cash Sickness program to see the extent to which workers are calling upon the program for help. In the beginning, it should be appreciated that because of its industrial characteristics, Rhode Island would not have been selected as the most desirable testing ground. Besides being densely populated and very highly industrialized, it has a great diversification of industry, with textiles, machinery and tools, and jewelry as its three major industries. There has always been in employment a much larger number of women than in most other states. Women have averaged 40 per cent of the working force and have approached 50 per cent particularly during the war years.

Herein, as is normally expected, lies to a considerable extent the poorer or non-selective risks.

What is equally apparent is that the period 1942–1945 would not have been selected as the most appropriate time to conduct such a test or actually undertake such a program as we did. The demands of the war program brought into industry older workers and women in great numbers. Such movements in and out of the labor market of persons having no genuine attachment to the labor market resulted in abnormal payments consistent with the abnormal conditions.

During this same period, our annual disbursements in the form of payments so greatly exceeded our income that the Fund itself was seriously threatened. At one time, in 1946, but only for a year, it became necessary to increase the employee tax to 1½ per cent, to help offset this heavy drain on the Fund. The critics of the program were quick in their attempts to attribute this financial predicament to the excessive malingering which allegedly was rampant. While admitting that this program, not unlike any other private or public insurance program, has had and will continue to have its worries in combating malingerers and fraudulent claims, I must say that this was by no means a significant cause of our financial ills. Rather, the load stemmed primarily from the authorized payment of benefits to three groups not originally encompassed.

You will recall that the Cash Sickness law originally provided for payments only to those persons suffering a wage loss through illness. However, during the period of financial difficulty, this original concept was extended to permit payment to workers who continued to receive wages or salary during periods of illness and to workers who received Workmen's Compensation. These two

changes, coupled with the more significant authorization to pay benefits in pregnancy cases, resulted in expanding the program considerably beyond its original scope and beyond the original estimated rate of expenditure. This made necessary a corresponding adjustment of the tax base.

But let us get back to the types of claims filed. In general, it can be said that the claim load (exclusive of those groups just mentioned) continuously displays characteristics not unexpected and quite consistent with the general morbidity and industrial pattern throughout the state. Whether it be age, sex, industry, or medical diagnosis, sample studies show the expected relationships.

Of course, again you must bear in mind that payment in pregnancy cases tends to distort greatly what would be normal findings. For example, in the distribution according to age there was the highest concentration of claims in the 20–29 age group. Thirty-one per cent of all claims were found in this group. Yet, if our system excluded payments in pregnancy cases, the size of this group would revert to normal since approximately one-half of all claims in this age bracket were for pregnancy.

A recent sample study produced additional interesting data. The ratio of claims of industrial workers to the total claim load bore a close relationship to the ratio of industrial workers to the total working force. This same characteristic kept reappearing in other groupings, such as age, sex, marital status, and industry or business.

It was further revealed that 65 per cent of all claims analyzed fell into four major categories of illness: 22 per cent were for pregnancy; 18 per cent for injuries or the ill effects of poisoning; 14 per cent for diseases of the digestive system; and 11 per cent for diseases of the circulatory system. The remaining 35 per cent were distributed among eleven other types of illnesses, with 7 per cent shown as suffering from diseases of the nervous system and sense organs, including mental disorders.

Again, of the claims analyzed, 57 per cent were filed by females. Of that 57 per cent, four-fifths were married. The average age of all claimants was 39 years, with the 45 year average for males 10 years higher than that for females. Only 20 per cent of the male claimants in the group were under 30, while nearly one-half or 49 per cent of the females fell into that age group, again due to pregnancy cases.

The number of cases analyzed was necessarily small, yet it has been sufficient to provide some interesting data, and it is felt that larger cross-section studies will not do great damage to the ratios and characteristics mentioned above. In any event, this analysis might serve to focus your minds on the extent to which the morbidity data accumulated offer a challenge of enormous importance to public health activities, especially to those concerned with prevention, rehabilitation, and the general subject of geriatrics.

We might further ask ourselves what happens to the person in the older age group who is disabled and who has exhausted his disability insurance benefits? Or, if you will, what of that same person who may not be covered by the program? What of the high percentage of claims during pregnancy? And what of the pregnant wives of men who contribute to this system of disability insurance but who themselves (the wives) are not covered by the program? To what extent is our program improving or can it improve the health of workers? To what extent are its benefits being used as financial relief to low income families from the added burden of medical expenses. These are certainly matters for conjecture and study, since this whole program of social insurance, particularly disability insurance, is one of local and national importance.

In studying this program, we should not lightly skip over other significant factors. Should temporary disability insurance of this type be coupled with a maternity benefit program? Should it be extended to cover a program of medical care? Is it logical to extend payments to persons who suffer no wage loss or who may be receiving other compensation such as Workmen's Compensation?

Let us not forget either the vital part played by the medical profession in the administration of this program. Its very backbone is medical certification, advice, and counsel. It is a real challenge to the individual practitioner, as a professional man maintaining his role of assistance to the individual, while at the same time assuming his responsibility to society. On the determination of whether he can or will fulfil this dual role rests the future of such a program.

While the Cash Sickness program in Rhode Island is out of the early experimental stage, having been in operation for 6 years, it is hoped that it will never be out of the research stage. There is a constant effort to improve the plan and to improve the system and administrative structure through which it is carried out. Since its original passage, many changes have been made and no doubt more are contemplated.

In any event, Rhode Island has provided experience for other states adopting this type of social legislation or considering its adoption in the near future. California and New Jersey already have systems in operation. Ohio, Washington, New York, Illinois, and others are investigating its possibilities. From the fact that so many representatives of these states have come to Rhode Island to observe the organization and administration of disability insurance, there is evidence that our experience with the plan is considered worthy of study. As always in a pioneer endeavor, errors have been made. And again, as always in a pioneer endeavor, we regret that some other state was not first to provide Rhode Island with its experience so that we might have profited by its trials and errors. However, Rhode Island workers have been given a measure of protection during illness at a time when it is most needed, and social legislation thereby is moving another step forward.

1949 Ricketts Award

Dr. Ludwig Hektoen, Professor Emeritus of Pathology, and Dr. Russell M. Wilder, formerly Chairman of the Department of Medicine, University of Chicago, received the 1949 Howard Taylor Ricketts Award. The awards and medals were presented on May 23, 1949, at exercises held at the University of Chicago Clinics. At this time Dr. Wilder who is now head of the Department of Medicine, Mayo Foundation, delivered an address entitled "The Rickettsial Diseases: Discovery and Conquest."

Dr. Ricketts in whose honor the award is made, first established the presence of specific organisms as the causative agents of the group of diseases now known as the rickettsial diseases—Rocky Mountain spotted fever, rickettsial pox, and others.